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ABSTRACT

A working group on children's problems was convened in Moscow from November 30 to December 3, 1976 by the World Health Organization (WHO) Regional Office for Europe. The meeting was attended by 16 temporary advisors of Eastern and Western Europe and WHO headquarters. This report reflects the work of this group. The report considers all the problems of children aged 10-13 and all services provided for them--in school and out of school. The purpose of the conference was to get an overview by identifying the problem areas as well as overlaps, gaps and deficiencies in services. The report: (1) describes the characteristics of children of this age group; (2) presents the biological, psychological and social problems of these children along with possible solutions; and (3) presents an overview of solutions, from which common principles emerge, together with the conclusions and recommendations of the Working Group. (Author/RF)

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Problems of Children of School Age (10-13 Years)

Report on a Working Group

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Note

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The views expressed are those of the participants in the Working Group and do not necessarily represent the decisions or the stated policy of the World Health Organization.

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This report is also available in French and Russian.

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1. INTRODUCTION

1.1 Opening session

A Working Group on Problems of Children of School Age II (10–13 years) was convened in Moscow from 30 November to 3 December 1976 by the WHO Regional Office for Europe. The meeting was attended by 16 temporary advisers, from Czechoslovakia, Denmark, Federal Republic of Germany, Finland, France, Greece, Poland, Sweden, Switzerland and the USSR, 2 staff members of the WHO Regional Office for Europe and 1 representative from WHO headquarters.

Dr S. Doxiadis was elected Chairman, Dr D. Serduikovskaja was elected Vice-Chairman and Dr M. Wagner acted as Rapporteur.

The meeting was opened by the Regional Director, Dr Leo A. Kaprio. The Group was welcomed to Moscow by the Deputy Minister of Health of the USSR, Dr E. Novikova, who pointed out the importance of this age-group to those planning health services. In his opening remarks, Dr D. Sokolov, Chief, Strengthening of Health Services of the Regional Office, stressed the long commitment of the Regional Office to the health of children, as shown by the numerous meetings that it had convened on that subject. The Regional Office had cooperated with many international organizations working in the same field. He explained that the interdisciplinary nature of the present Working Group was vital to the success of the work because rapid changes in modern society had affected the psychological and social, as well as the physical development of children.

Dr P.S. Rönisch, WHO Regional Officer for Maternal and Child Health, also addressed the opening session of the meeting. He reviewed the historical development of WHO, both at the international and the regional level, and showed how the task of the Working Group fitted in with the activities of the Maternal and Child Health unit of the Regional Office.

1.2 Scope and purpose

The Regional Office for Europe of WHO is convening a series of three working groups to deal separately with the problems of children of each of the school age-groups: 5–9 years; 10–13 years; 14–18 years. The three working groups should provide the basis for a better understanding of the child and adolescent in society, which will be the subject of a conference in 1978.

The present Working Group agreed that there should be continuity between the three working groups on problems of children of school age. Thus, the reports of the three groups should be similar in arrangement, so that, together, they would provide a uniform series of documents on this

subject. In this regard, the report of the first Working Group[a] served as an important background document for the present Working Group; it is therefore suggested that readers of the present report should regard it as a continuation of this first report. The third report in the series will appear after the third Working Group has met in June 1977.

In order to ensure continuity between the three Working Groups, it was agreed that the scope and purpose of the three meetings should be, as far as possible, similar in nature. Dr M. Wagner, the Rapporteur for both the first and the present Working Group, described the scope and purpose of the former; this was accepted, in general, as applying to the present Working Group, and can be expressed in the following terms. Although wide differences exist between and within countries, to obtain a balanced view, all areas of the Region need to be taken into account because every country has children disadvantaged in one way or another. The meeting should consider all problems of the children in the age-groups under review – health, educational and social – and all services – health (in and out of school), educational, social and psychological – provided for them. Such a broad scope, while limiting the detail with which any one problem or service could be discussed was consistent with the purpose of obtaining an overview by identifying the problems and identifying overlaps, gaps and deficiencies in services.

The arrangement of this report follows that of the first report. It begins with a review of the characteristics of children in the age-group under consideration, as discussed by the Working Group. This is followed by a presentation of the problems of these children – biological, psychological and social – including some of the possible solutions to the particular problems discussed. Finally, an overview of solutions (services) is presented, from which common principles emerge, together with the conclusions and recommendations of the Working Group.

2. CHARACTERISTICS OF THE AGE-GROUP

The Working Group gave considerable emphasis to the characteristics – biological, psychological and social – of children 10–13 years of age, as these characteristics are relevant to and help to define the problems and/or solutions under discussion.

[a] WHO Regional Office for Europe. *Problems of children of school-age (5–9 years)*: report on a Working Group, Copenhagen, 24–28 November 1975. Copenhagen, 1976

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2.1 Population characteristics

The number of children in this age-group in Europe is shown in the Table (the European Region of WHO is not coextensive with Europe, as defined geographically, since it includes Algeria, Morocco, Turkey and the Asian part of the USSR, but the same general trends apply in it).

Population projections (1965–1980) for the age-group 10–14 years by geographical region (figures given in thousands)

Year	Europe	Western Europe	Southern Europe	Eastern Europe	Northern Europe	USSR
1965	36 556	10 789	10 496	9 500	5 772	22 686
1970	37 509	11 490	10 897	9 132	5 991	24 250
1975	38 318	12 325	11 359	8 010	6 625	23 199
1980	39 360	12 452	11 668	8 523	6 717	20 396

Source: World Health Organization. *World Health Statistics Report:* **28** (4) (1975)

The trends shown by the Table are essentially the same as those found for children 5–9 years of age, described in the report of the first Working Group. In the 15 years from 1965 to 1980, there will be a total world increase of 30% in the numbers of children 5–14 years of age, but this increase will be the result of increases in the developing countries. The European Region reflects this situation, for the increases in numbers of children 10–14 years of age are greater in the developing areas of the Region. Indeed, eastern Europe and the USSR show an overall decrease in the numbers of children in this age-group. These differences are the result of changes in the birth rate in the different areas of the world.

2.2 Biological characteristics

For nearly all children, the age range 10–15 years is marked by the onset of puberty. This biological event is of overriding importance to this age-group, as it has profound physical, psychological and social consequences. The first physical consequence is the onset of the adolescent growth spurt. Height is a more useful parameter than weight for measuring this growth spurt, as it

is less affected by small variations in nutrition or by minor illnesses. There is a sex difference in the height growth spurt, as boys have a later and longer spurt than girls. In Europe, the fastest growth occurs on the average at 12 years in girls and 14 years in boys. As a result, 11-, 12-, and 13-year old girls in Europe are, on the average, taller and heavier than boys of the same age.

Physical growth and the time of onset of the growth spurt depend on genetic and environmental factors. Environmental factors which have been found to influence growth and development and the onset of the growth spurt include social conditions, nutrition and climate. In the developing areas of the European Region, poor social conditions and malnutrition can lead to retarded growth and retarded onset of the growth spurt. In most of the European Region, however, as in most of the world, recent years have seen both an acceleration of rates of growth and an increasingly early time of onset of the growth spurt. Young adolescents are taller now, as a result both of an actual increase in size and of earlier physical maturation.

A second physical consequence of the onset of puberty is the onset of sexual maturation; this begins for most children during the age range 10–13 years. The age of onset of sexual maturation varies considerably among individuals and groups. In some European populations, the first sexual changes may be observed before 9 years of age in girls and before 10 years of age in boys. Nevertheless, at the age of 14, some boys and girls may not have begun their sexual development, while others have completed it.

The age of onset of sexual maturation has fallen steadily and considerably over the past 100 years. Menarche is the most commonly used indicator of the onset of sexual maturation in girls. As with the onset of the physical growth spurt, the onset of sexual maturation (as measured by menarche) has been shown to be influenced by environmental factors. The factors of this type associated with an earlier age of sexual maturation include better nutrition, better social conditions, and urbanization. Earlier menarche in girls is associated with later menopause and hence a longer fertility period. While the Working Group recognized that there must be many other consequences of earlier physical and sexual maturation, it was agreed that very little was known of such consequences.

In reviewing the biological characteristics of the 10–13 year age-group, the Working Group also considered the mortality and morbidity characteristics of these children. The mortality for children in this age-group is one of the lowest for any period of life and shows a converging trend towards a threshold at around 40 deaths a year per 100 000. In countries in the Region where the death rate is still significantly higher, as in southern Europe, there has been a rapid fall in mortality in recent years as a result of the decrease in infectious diseases. In countries where the rate has already reached this threshold, as in northern Europe, there has been no further decrease, since the major residual causes of mortality, namely violent death and tumours, remain at the same level in all countries. Suicide first appears in this age-group

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as one of the categories of violent death, and while it still contributes only a small proportion of deaths, it is apparently on the increase among those children.

The morbidity of children 10–13 years of age is also quite low, but unlike mortality, very little is known about it. It is known that major causes of morbidity include obesity, mental retardation, convulsions and chronic respiratory disease. While even less is known about mental illness and psychosomatic disorders in this age range, the Working Group recognized their importance and that, in the future, it may become clear that their contribution to the morbidity picture is a major one.

2.3 Psychological characteristics

The age range 10–13 years falls between childhood and adolescence, and has consequently not received sufficient attention. It is known to be a period of life when a great deal is taking place psychologically, but little is known about it. Furthermore, while the process of changing from a child into an adult obviously has its psychological aspects, it is a process which is so profoundly influenced by the microsocial environment (family, school, local community) and the macrosocial environment (society in general, culture) that any attempt to describe the psychological aspects in isolation from these social factors would be difficult, if not artificial and undesirable. Nevertheless, while psychological development during this period clearly depends on external conditions, it can be characterized in general terms, if it is kept firmly in mind that such characterization is descriptive (rather than analytical) in nature.

The period is characterized by the beginnings of the acquisition of a consciousness of abilities and skills. This in turn brings about the beginnings of a personal concern with the problems of choosing a career or job. Another psychological characteristic of this period is a rapidly increasing self-awareness, which is focused particularly on the rapid changes taking place in the size, shape and sexuality of the body. This increasing self-awareness is, however, counterbalanced by a rapidly increasing awareness of concern for, and dependence on others, and particularly on persons outside the family. The increase in extrafamiliai social learning results in a widening social environment which includes increasingly important peer groups.

Cognitively speaking, the period is characterized by the development of adult-like reasoning skills, combined with a residual, more child-like vulnerability, resulting in an enthusiasm for and ability to learn rapidly about the adult world.

2.4 Social characteristics

The Working Group considered the social characteristics of this age-group in terms of the continuing process of socialization of the child. This is the

process of learning social roles and ways of performing them, values, norms of conduct, the internalization of moral standards, and the proper or accepted perception of the surrounding world. Through this process of socialization, the child learns how to act as a member of society and how to coexist with its other members.

Disturbances or difficulties in the process of socialization are likely to produce social deviance. This may also be caused by psychological and/or biological factors, but the focus here is on the social factors. Social deviance is social behaviour which is in conflict with the social norms and expectations of a particular group or society and which lies outside the range of socially acceptable nonconformity to these norms. Such social deviance can be "negative", if the deviation is below the norm, e.g., delinquent behaviour, or "positive", if it is above the norm, e.g., exceptional intelligence or talents. There is a dynamic two-way relationship between the process of socialization and deviance. On the one hand, the process can begin with poor socialization, so that proper norms of conduct have not been internalized, and this may lead to deviant behaviour (e.g., delinquency), which in turn may lead to a perpetuation, if not an increase, of the poor socialization. On the other hand, it can begin with a preexisting deviance (e.g., mental retardation), which may lead to a decreased ability to learn socially accepted patterns of conduct, and this poor socialization in turn leads to a perpetuation of the deviance. This dynamic interrelationship can be presented in a simplified way as follows:

Once this vicious circle has begun and deviance and poor socialization exist, for whatever reason, a process of resocialization is necessary to bring social characteristics back, or at least closer, to the social norm. The problems of social deviance will be discussed in more detail in section 3.3 of this report.

The socialization process for children 10–13 years of age takes place mainly in the family, the school, and peer groups. The family is of fundamental importance in the preparation of the child for his future social life. It is in the family that the child, at earlier stages in his life, learns language, customs, behaviour patterns, moral standards, self-evaluation and the evaluation of others. The family, to a large extent, influences not only the content but also the form of the socialization process by providing appropriate patterns of conduct for imitation. The age range 10–13 years, however, sees the beginning of a change in family relations, which become looser. Parents are

less able to watch over and control the child's physical and social environment. In some cases, children are becoming the intellectual equals of their parents, although they still lack experience. Children in this age-group may begin to seek alternatives to parental patterns of conduct. The line between acceptable and unacceptable (deviant) social behaviour becomes increasingly difficult to define, particularly when there is lack of understanding in the family. In some cases, particularly in the developing areas of the European Region, this period may even find the child voluntarily leaving the family setting permanently.

In most areas of the European Region, the age range 10–13 years finds essentially all children still in school. (In the developing areas of the Region, however, leaving school during this period is quite common.) Since the primary function of the school is to assist the child's intellectual development, the degree to which the school participates in the process of socialization varies considerably and depends largely on the teachers' professional orientation. The school can potentially play an important role in the socialization process of children, particularly in areas of social pathology, where it can correct the errors in, and fill the gaps left by the incomplete socializing process in the family. The school can also play an important role in the identification of social deviants for, while the family is likely to protect young deviants and keep their deviant tendencies secret, such tendencies will not be concealed in school and the deviance can be identified.

An important social characteristic of children 10–13 years of age is the increasing role of peer groups in the process of socialization. These peer groups constitute a different social milieu that increasingly strongly influences personality formation and behaviour. The activities of such groups usually remain beyond the control of adults or family. In peer groups, the child becomes acquainted with specific subcultures that often have their own rules based on their own social norms and values, not necessarily conforming to those offered by the adult world. Indeed, for children coming from poorly functioning families, such peer groups may become basic reference groups. Peer-group relationships are an important and normal part of the process of socialization. However, children may become available for recruitment to deviant peer groups – in general, in inverse proportion to the extent to which their self-images and self-esteem are anchored in satisfactory relationships in the home and school.

In order to understand more completely the factors influencing the socialization process of children 10–13 years of age, it is necessary to go beyond the family, school and peer groups (microsocial factors), where the child is functioning on an interpersonal relationship level, to the level of macrosocial factors, i.e., the economic changes and social processes taking place in the larger society. What takes place in the family and in the school is largely determined by the family's and school's total social situation. Thus the recent changes in technology and economics, and their social, demographic

and economic consequences, such as changes in employment and housing conditions due to urbanization and industrialization, in the roles and occupational status of women, in education and culture, and in value systems, all have a major impact on the socialization process of children. To take only one example, as a result of industrialization and urbanization, the informal ties and the role of primary groups, such as the family, have become weaker. So far, insufficient attention has been given to the importance of these macro-social factors in the socialization of children.

The Working Group also gave special attention to one aspect of the socialization process of particular importance to this age-group – the need to develop personally satisfying, socially appropriate leisure activities. The biological rhythm includes an active phase of increased energy consumption alternating with a relaxation phase of energy renewal. This relaxation phase should include mental and emotional relaxation, such as cultural and aesthetic activities and entertainment, conversation, idleness, and also physical relaxation, such as athletic activities and sports. As the children in the age-group under consideration spend more and more time outside the family and school, the development of optimal leisure activities is an increasingly important social need.

3. PROBLEMS OF THE AGE-GROUP

For discussion purposes, the Working Group divided these problems into three categories – biological, psychological and social. The problems are similarly categorized in this report, but the Group, particularly because of its interdisciplinary nature, repeatedly emphasized the artificial nature of such categorization and the obvious overlapping and, more importantly, interactions between these three aspects of the developing child. It is equally arbitrary and artificial to discuss problems and not to discuss solutions to these problems at the same time. Consequently, this report will follow the lead of the Working Group and present some of the suggested solutions when individual problems are discussed. The solutions considered in chapter 4 of the report are overall solutions (or services) designed to meet many of the problems now to be presented.

3.1 Biological problems

As mentioned in the earlier section on the biological characteristics of children 10–13 years of age, recent years have seen an acceleration in the absolute growth of children, earlier onset of the growth spurt, and earlier onset of sexual maturation. Furthermore, these changes are influenced by

environmental factors and consequently vary among different groups of children in different geographical areas. As a result, it is inappropriate to apply, in a given area, growth standards and sexual maturation standards based on data for children from other geographical areas or established many years ago. It is essential for such standards to be developed specially for the areas concerned, and they must then be updated at least every 10 years.

Normal physical and sexual development can be measured in two ways: (1) a generalized method based on large groups of children of different chronological ages; and (2) an individualized method in which the growth and development of individual children is followed over time. Both methods are important and should be used in developing standards and in conducting research on growth and development. Recent research on children 10–13 years of age shows that growth and development during this period is mainly influenced by environmental factors, such as social conditions, nutrition and climate; as yet, however, there are insufficient data on the complex interrelationships between the environmental factors and growth and sexual maturation.

Nearly all studies of growth to date have focused on anatomical development – height, weight, skin thickness, etc., – and have not included measures of functional development. There is an urgent need, for example, for the development of physical activity standards for children in this age-group. What is the optimal amount of daily physical activity for these children? What is the minimal amount of daily physical activity necessary for normal growth and development? What are the maximal levels for specified physical activities above which damage may be done to the rapidly growing body? While such studies have already begun in the USSR, the Working Group knew of no research on this important subject in other areas of the European Region.

While the Working Group recognized that the rapid growth and sexual maturation of children in this age-group must have many psychological and social consequences, these consequences are very little understood and should therefore be studied. The studies should be conducted by interdisciplinary groups of scientists.

To find solutions to these various problems, the Working Group agreed that future research on the growth and development of children in this age-group should:

- focus on the influence of environmental factors;
- include the study of functional components;
- include the interdisciplinary study of the psychological and social consequences of rapid growth and development;
- include the search for better parameters of growth and sexual maturation;
- provide for improved collaboration among researchers from various disciplines.

The Working Group's discussion of biological problems in children 10–13 years of age included consideration of infectious and chronic diseases. While infectious diseases are no longer a public health problem in this age-group in the developed areas of the European Region, they remain important in the developing areas. At the same time, increasing population movements in the European Region require continual vigilance throughout the Region from the point of view of the spread of infectious diseases and the immunization programmes needed to combat them.

Chronic diseases, however, remain an important problem in this age-group throughout the European Region. The nature of these chronic diseases has changed in recent times and the changes are believed, in some cases, to be related to changes in modern society, such as industrialization, pollution and urbanization.[a] Unfortunately, little is known about the morbidity and epidemiology of chronic diseases in this age-group, although a recent Working Group of the European Regional Office of WHO focused on one disease of this type, namely chronic respiratory disease.[b]

The present Working Group recognized the urgent need for more studies of the morbidity of children in this age-group. Because little is known of morbidity and because it may include both psychosomatic disorders and mental disorders, it is important, when developing assessment programmes for these children, to include a non-specific complaint or risk category.

Considerable attention was given by the Group to the effects of chronic disease in this age-group, and in particular to those concerning the individual child. The first effect on the child is well documented, and concerns growth and development. Because this period sees the onset of the growth spurt and that of sexual maturation, the child's growth and development is particularly vulnerable to the effects of chronic disease. Delayed growth and/or sexual maturation may result from chronic disease, and this accounts for some of the children suffering from retarded physical and sexual development. Since many normal 13-year old children have not yet started their growth spurt or sexual maturation, it may not be apparent to the physician or teacher, or the child himself, that development is retarded.

A second effect of chronic disease on the child 10–13 years of age is that on the child's self-image. As indicated earlier in this report, this period is one of rapidly increasing self-awareness, particularly of the body, and the child with a chronic disease is especially prone to the development of a distorted or confused image of himself. Because of these effects of chronic

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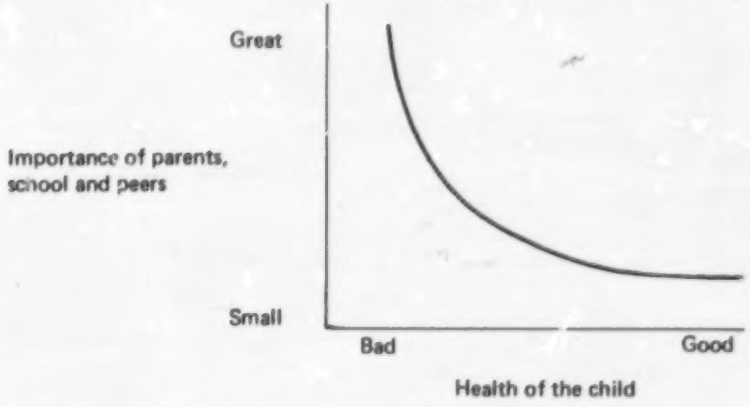
[a] The report of the first Working Group contains a more detailed discussion of this issue.

[b] WHO Regional Office for Europe. *Management of respiratory diseases in children*: report on a Working Group, Rotterdam, 3–7 March 1975. Copenhagen, 1975.

disease on the physical and psychological development of children in this age-group, the Working Group emphasized the importance of assisting the chronically ill child in gaining the best possible understanding of: (1) his own disease; (2) his own body and its present and future development; and (3) the effects which the disease is having and will have physically and psychologically.

The effects of chronic disease in the child on the child's family, school and peers was also discussed. Chronic illness in children 10–13 years of age affects and is affected by family, school and peers. The importance of these social factors in the development of the normal child has been reviewed earlier in this report, but their importance is even more critical when the child is not normal. This relationship can be illustrated in a simple way by the following diagram:



Because of the critical importance of these social factors in the satisfactory development and socialization of the chronically ill child in this age-group, the Working Group emphasized the need to consider the psychological and social environment in the management of chronic diseases in these children. The aim of such management should be to normalize this environment to the greatest extent possible.

With regard to the medical management of chronically ill children in this age-group, normalization should include consideration of where management of the illness is to take place. Outpatient management, with the child living at home, is clearly the most normal and the preferred procedure. Management regimens for the various chronic diseases in children need to

be reevaluated in the light of the latest technical advances, the increased use of other types of personnel, such as home nurses, the development of transportation systems, and of family education programmes, so as to determine the maximum extent of outpatient management possible. When inpatient management is unavoidable, alternatives such as day wards (nights are spent at home), week-day wards (weekends are spent at home), or non-hospital-like facilities ("schools" or "sanatoria", with nursing services) should be developed so as to normalize the environment as much as possible. When the more standard type of hospital inpatient management is unavoidable, careful consideration must be given to the hospital environment, as it has been shown that hospitalization affects both the physical and mental development of children. The Working Group agreed that children 10–13 years of age should be hospitalized in children's departments or adolescents' departments, regardless of the nature of their disease. There was also agreement that such children's departments should provide education, recreation, and as frequent contact with family and peers as possible. Finally, there was agreement that periods of inpatient management should be as short as possible.

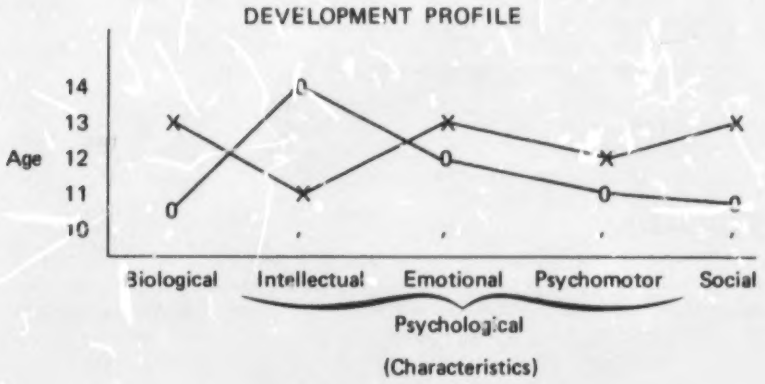
With regard to the educational management of chronically ill children in this age-group, normalization should include placement in as normal as possible a school setting. This principle was discussed at some length in the report of the first Working Group and will also be discussed in section 3.2 of this report.

From the point of view of normalizing the management of chronically ill children in this age-group, it is today both necessary and possible to increase the role of the family and the child himself in the management of the illness. In certain chronic diseases, such as diabetes, family- and self-management has long proved effective – medically, psychologically and socially. More recently, increased family- and self-management has been found most effective in other chronic illnesses in children, such as haemophilia. Investigations aimed at increasing the role of the family and the child in other chronic illness in this age-group is both desirable and necessary.

3.2 Psychological problems

The psychological development of children 10–13 years of age includes intellectual development, emotional development and psychomotor development. The levels and rates of development of these three psychological characteristics are to a considerable extent independent of each other and, furthermore, all three are also quite independent of the levels and rates of biological (physical and sexual) development and social development. As a result, the period 10–13 years of age is characterized by wide variations, both within and between individuals, in the levels of development of these

various characteristics. This most important fact, which underlies many of the psychological problems to be discussed, is illustrated by the following diagram:



0 = boy, chronological age 12 years

X = girl, chronological age 12 years

The diagram illustrates the wide variation in characteristics, both within and between individuals, even though the chronological age is the same.

The development of such profiles for children could be of great value, both to the child himself, as a means of increasing self-understanding, and to those caring for the child – parents, teachers, school health personnel, family physicians – as a means of increasing their understanding of, and ability to help the child. They could also be of value to scientists working to learn more about children; by making inventories of such profiles and studying them epidemiologically, they could increase their understanding of normality and of deviations (new morbidities) in children in this age-group.

A major obstacle, however, lies in the path of developing such profiles – the lack of a reasonably simple but reliable means of evaluating the functional level of these various characteristics. The pioneering work of Tanner[a] has resulted in such an instrument for determining the level of development of one of these characteristics, namely the biological. The Tanner Scale has

[a] Tanner, J.M. *Growth in adolescence.* Oxford, Blackwell Scientific Publications, 2nd ed., 1962

proved to be simple and reliable and the Working Group repeatedly recommended its widespread use. With regard to the three psychological characteristics, a variety of instruments exists, and it was the general consensus of the Group that such instruments are of sufficient reliability to be employed in the development of such profiles, as long as they are considered descriptive and not predictive. Warnings were voiced that the use of these psychological instruments for predicting the future development of these children or for counselling is inappropriate because of their social biases.

It was therefore recommended that the search should be continued for better, simple, reliable instruments for assessing the level of development of the three psychological characteristics. The biggest obstacle in the way of completing a development profile, however, is a lack of a reliable instrument for evaluating the level of social development (or level of socialization). This problem will be discussed in section 3.3.

The wide variability in psychological and social characteristics within individuals, between individuals and between groups, at different ages, underlies one of the problems in working with children in this age-group – the difficulty of defining the borderline between normal behaviour and problem behaviour. How this borderline is defined depends on the extent of knowledge of behaviour patterns and their variability in children 10–13 years of age, and also on the training and background of those involved in the management of these children. Thus, for example, a child may be seen as a behaviour problem by the family but not the schoolteacher, or by the teacher but not the physician. For this reason, it is important for the family, school personnel and health personnel to work closely together, and for knowledge of behaviour patterns in children of this age-group to be more widely disseminated.

Psychological problems in children 10–13 years of age can be related to a number of factors, of which the commonest is probably growth and puberty. The psychological problems related to growth and puberty are of two types: (1) those of children with normal variations in growth and puberty who perceive themselves as abnormal because of their own ignorance or that of other people; and (2) those of children with abnormal growth and/or puberty who develop secondary psychological problems. In both cases, the roots of the psychological problems lie in a lack of knowledge on the part of children, parents, teachers, physicians, etc., of growth and development during this period. All such people can and should be taught the basic principles of growth and puberty, and such teaching can be made much more effective by the use of the Tanner Scale and the profile previously described.

Psychological problems in this age-group can also be related to an underlying somatic disorder. Thus children who suffer from minimal brain dysfunction frequently exhibit problem behaviour. All children in this age-group with psychological problems should therefore undergo a thorough medical examination.

Psychological problems in children 10–13 years of age can also be related to school. In most areas of the European Region, it is during this period that the child first experiences streaming – the process whereby children at school are divided into different groups according to their ability. The fact that a child's performance at school or perhaps in a test will irrevocably determine his or her entire future education and career can subject the child to great stress; in many cases, the child's family is also affected, and this again has repercussions on the child. It is not surprising, therefore, that psychological problems may result: recently, in some areas in Europe, an increase both in school phobia and in truancy has been noted in children involved in this streaming process. In extreme cases, a quite small but nevertheless significant number of suicides associated with streaming have been reported in children 10–13 years of age. For these reasons, it was recommended that the use of streaming as well as of other educational procedures should be carefully reconsidered in the light of their effects on the psychological development of children in this age-group.

Peer relationships can also be associated with psychological problems in this age-group. The importance of the growth of peer relationships to normal psychological and social development has already been pointed out. At the same time, intolerance of developmental deviations is common in this period and can lead to psychological problems in the victim. The level of intolerance of deviations is in part related to the level of socialization of the children. In more severe instances, a child who is perceived by his peers as deviant for whatever reason may be subjected to mobbing – violent aggression against an individual by a group of peers. Adults can sometimes unwittingly endorse if not enhance this intolerance of percieved deviance by emphasizing differences among children in talking to them or, more importantly, by emphasizing such differences in designing services for children. As an example, segregating children of this age-group in special schools for the physically or intellectually deviant, whether for the physically handicapped or the athletically superior, for slow learners or for high academic achievers, tends to exaggerate this intolerance by emphasizing the deviant, rather than the normal characteristics. Such segregation also reduces the opportunities for the normal socialization both of the segregated children, who are denied the experience of associating with the normal range of peers, and of the non-segregated children, who are denied the experience of associating with extremes in the range of peers. For these reasons, it was recommended that all educational or other policies involving the segregation of children of this age-group should be reevaluated in the light of these facts.

It is clear that, in spite of the current lack of carefully collected statistics on this subject, the psychological morbidity of these children, as indicated above, is considerable. Serious psychiatric problems, however, are rarer in children 10–13 years of age. The commonest psychiatric symptom in this age-group is depression which, in the most severe cases, can lead to suicide.

While suicide remains relatively rare in these children, it has been increasing recently and deserves close continuing scrutiny.

The multifactorial and multidimensional character of psychological problems in this age-group make it essential that these problems should be managed by cooperation between parents, school personnel and school health personnel. School health personnel need to develop preventive programmes including the education of children, parents and school personnel in normal growth and development and the early identification of problems. School health personnel also need to seek out children in need of help and be prepared to act as advocates for these children in the school.

3.3 Social problems

3.3.1 *Social deviance*

In section 2.4 on social characteristics, the process of socialization of children was reviewed, and it was pointed out that disturbances or difficulties in this process can produce social deviance. This is an important problem of children in this age-group and its nature and possible management will now be considered. It is important to remember that social deviance can be "negative" (social behaviour lies below the acceptable normal limits) or "positive" (the deviation is above the norm). It is equally important to remember that social deviance can be "primary", where a preexisting biological or psychological deviant condition (for example mental retardation) may lead to poor socialization, or "secondary", where the process begins with poor socialization, which in turn may lead to deviant behaviour.

In the discussion of problems of children 10–13 years of age, it is essential to include social deviance because it is in this age-group that the first symptoms of future deviant behaviour appear. Juvenile delinquency is perhaps the most extensively studied form of negative social deviance, and in one study, certain delinquent acts were found to occur for the first time at the following ages: stealing – 11.5 years; truancy – 12.5 years; running away from home – 13.2 years; destruction of property – 13.0 years; attempted car stealing – 13.9 years; drinking alcohol outside the home – 14.5 years. Although these particular data are from the USA, there is no reason to believe that, if similar data were available in Europe, there would be any significant difference.

The etiology of social deviance is poorly understood, but it is known that biological, psychological and social factors are involved. Although our knowledge does not permit us as yet to specify etiologies precisely in individual cases, considerable information is available on the social context in which deviant behaviour occurs. This knowledge of the phenomena and conditions associated with deviance is of crucial practical importance for, while it may not always enable us to explain the mechanisms of deviance

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formation, it does make it possible to identify individuals or groups at risk for social deviance.

Since juvenile delinquency is the commonest form of social deviance in children under 14 years of age (other forms of deviance, such as alcoholism, sexual deviations, and prostitution occur later) and since a good deal of information is available on delinquency, it will be used to illustrate the principle of identifying those factors associated with deviance in order to establish risk groups. Using data from a number of studies in various countries (France, Poland, Sweden, United Kingdom, USA) the following factors were found to be positively correlated with the occurrence of delinquency: large family size, other delinquents in the family, lack of participation in various groups and associations, lack of religious beliefs, lower social class, poverty, mother working outside the home, broken families, poor school achievement, truancy, alcoholism in parents, low intelligence, urban areas, and processes bringing about social disorganization, such as rapid industrialization. It is important to repeat that it is not possible to establish simple casual relationships between the above factors and the occurrence of delinquency, nor can the importance of particular factors be assessed. Indeed, many of the factors – for example, family size, social class and poverty – are strongly intercorrelated and we do not as yet know which of the variables in such a cluster are of decisive importance. Nevertheless, such data make it possible to select children at higher risk for poor socialization and subsequent deviance, and therefore in need of special attention.

Before any discussion of possible solutions to the problem of social deviance, one further issue needs mentioning: the problem of social response to deviance, including the process of negative perception of deviants, labelling and stigmatization. Whatever the etiology of the deviant behaviour may be, it is the inappropriate social response of adults as well as children which tends to perpetuate, if not accentuate the problem. This important fact must be kept in mind when developing solutions (services).

With regard to solutions to the problem of social deviance in children in this age-group, some general preliminary comments are in order. Firstly, as regards social factors, social deviance is the result of faulty socialization of the child. If, therefore, the phenomena of deviance are to be changed, the socialization processes must also be changed. All too often, in the past, measures have been taken to deal only with the deviant behaviour itself without any consideration of the underlying poor socialization. Secondly, childhood socialization is a cumulative process, and it rarely happens that deviance results from the action of one of the previously mentioned factors alone. It is a situational syndrome, in which several unfavourable factors coexist. Consequently, solutions must be many-sided and take into account many aspects of social life that may lead to deviance, including macrosocial processes. In this regard, it must be remembered that any action taken will always be limited by the extent to which social conditions can be altered.

Action directed against social deviance should begin at the preventive level. The Working Group pointed out that, since the amount of social deviance varies among communities, it is clear that prevention is possible. Furthermore, we have seen that deviant behaviour may first be observed during the period under discussion, so that prevention must begin at this time. Indeed, in one investigation of delinquent boys aged 15 and 16 who had broken the law, it was found that their school teacher had noticed certain differences from other pupils, such as a lower sense of duty and responsibility and lower respect for the rights and feelings of their peers, as early as 10 years of age. Prevention programmes should focus on risk groups, including both those at risk for "primary" deviance, i.e., children with preexisting biological or psychological deviances, whether positive or negative, whose socialization needs special attention, and those at risk for "secondary" deviance, i.e., children living in social conditions which predispose to poor socialization.

Approaches to the problem of social deviance should also go beyond prevention and include services aimed at the resocialization of children already exhibiting deviant behaviour. Here it is necessary also to include services for positive deviants -- exceptionally intelligent or talented children, who are troublesome to teachers at school, because they raise problems which may go beyond the teachers' competence, unpopular with peers, because their interests go beyond those of the group, and whose talents are being wasted because of loneliness and misunderstanding. In this case, clearly, the purpose of the services provided is resocialization and not correction of the deviance itself. Resocialization services, whatever the type or cause of the deviance to be dealt with, must be very carefully planned so as not unwittingly to reinforce it by inappropriate social responses, such as segregation and/or labelling.

The fact that problems of social deviance in children are highly complex, multifactorial, take the form of a vicious circle, and are as yet poorly understood, makes it difficult to know where to begin in dealing with them. While each particular situation has to be dealt with individually, it was suggested that, before any action is taken in any situation, it is necessary to:

(1) identify the situations and phenomena where improvement is needed;

(2) understand the nature of the deviance and its sources;

(3) identify the socializing agents and agencies whose performance must be improved; and

(4) establish a model programme which includes innovative socialization processes, goals and procedures, and the role of socialization agents, and addresses the problems of resistance to change.

For several reasons, it appears that, in programmes for improving the socialization of children, particular attention should be given to the school.

Since research indicates that socially deviant children often come from families which are broken, of low educational standard, poor, and have other deviant members, it is not reasonable to expect that many such families will be able to correct the socialization process of their children by themselves. In such cases, the school can have a compensatory function. While school personnel are often not yet prepared professionally for such tasks and in many places do not yet see themselves involved in the life of their pupils outside school, nevertheless, as a first step, it seems easier, in general, to train teachers, rather than parents, to work on deviance prevention.

It is clear that, in developing such programmes in the school, close cooperation between the parents, school staff, school health personnel and social institutions in the community is essential. The Working Group felt that in countries such as Czechoslovakia, where the local paediatrician is at the same time the child's physician, the school physician and the consultant to social institutions for children in the neighbourhood, such cooperation is greatly facilitated.

Part of the solution to the problems of social deviance in children must include further research. While it is clear that such research is made difficult by the multiplicity of biological, psychological and social factors involved, the newer research methodologies, such as multivariant analysis, are bringing the study of the socialization of children within the realm of possibility.

One urgent research task was mentioned earlier in section 3.2 – the need to develop a reliable instrument for evaluating the level of social development (or level of socialization) of these children. The ability to establish complete development profiles for children in this age-group awaits the development of this social instrument, and research on this subject should receive high priority.

3.3.2 *Problems of leisure*

As indicated earlier, the Working Group gave special attention to one particularly important aspect of the socialization of children 10–13 years of age, namely the development of personally satisfying and socially appropriate leisure activities. The organization of such leisure activities presents a number of important problems. The scientific and technological revolution of recent times, while resulting in more leisure time, has also resulted in more "brain-work" and the need for leisure which promotes a fuller, more balanced life, rather than just something to "keep children and young people out of trouble". For as children in this age-group move more away from the family and need to begin to plan and become involved in their own activities, the leisure "habits" which they develop will form the basis for their patterns of leisure for the rest of their lives.

A first, most difficult and complex problem in the organization of leisure activities for children of this age-group is to find the proper balance

between adult-initiated and supervised leisure and self-initiated and self-controlled leisure. Several issues are involved here. Leisure activities should be purposeful, useful, ennobling, but who is to define what is useful, the adult or the child? And useful to whom: the child, the adult, or society? Children need to be guided into selecting activities which promote life-long satisfaction from leisure, but how can this be done while still allowing for spontaneity, independence, creativity and the ability to choose wisely for oneself? Is it possible to plan or organize for the child's real need for idleness – to think, dream, gaze out the window ("doing nothing")? If adult supervision is provided for a particular group activity, children who need to be free of adults (or who are, at the time, reacting against adults) will not participate; if, however, there is no adult supervision of this same group activity, there is a danger that an over-aggressive minority will take over and the more passive children will not participate. There is a tendency for adults to organize children's leisure time in the same way as they organize children's educational time. Such a tendency has an inherent danger for children 10–13 years of age: a feeling that their lives are over-organized and a wish to revolt against such control. Thus alienation through leisure can be produced in the same manner as alienation through work (school). Finally, is it possible to plan leisure activities for those children who, through poor socialization, have already developed some degree of alienation from adults or antisocial attitudes? The foregoing discussion makes it clear that leisure is an integral part of the socialization of children in this age-group, and that management of leisure activities can promote or inhibit normal social development.

A second problem in the organization of leisure activities involves the role which these activities should play in providing for the optimal physical development of children. The industrial revolution not only reduced the amount of physical activity required in work, it has also tended to reduce the amount of physical activity involved in play (leisure). With the advent of such technological advances as television, leisure has become more receptive and passive. Similarly, the advent of "big sport" has meant that, while, say, 10 young people are extremely active, another 1000 watch them passively in the stadium, and perhaps yet another 10 000 on the television at home.

Lack of adequate daily physical activity, especially during the growth spurt occurring in this period, may result in dyskinesis – limitation in movement ability. A number of different issues are also involved in this problem. Where is the borderline between physical education, a legitimate and essential part of the child's work (school), and physical culture, a legitimate and essential part of the child's play (leisure)? Where is the borderline between physical culture and competitive sports? To what extent should physical culture programmes be devoted to physical activities and games for all children and to what extent to the development of the optimal physical abilities of the athletically gifted? What are the minimal levels of activity required for children in this age-group in order to prevent dyskinesis? What are the maximal allowable

levels of activity for such children participating in competitive sports, beyond which bodily damage may occur? What are the psychological and/or social risks to children involved in competitive sports (and to those who are not)? Is the phenomenon of "big sport" of positive value to children in this age-group by providing them with positive heroes (rather than negative heroes, such as violence-seeking movie cowboys) or is it of negative value because it segregates and implies the superiority of the genetically-determined athletically gifted? All of these issues are of critical importance to those responsible for the planning of leisure activities for this age-group. For this reason, the Working Group recommended that a separate meeting should be organized in the future to consider the problems of physical education and physical culture.

A third problem involved in the leisure activities of children in this age-group is the role played by television. Studies have confirmed that these children spend a large number of hours watching television. Without exception, the participants, representing many countries in the European Region, felt that the quality of television programmes in their areas could be improved, especially with regard to children as viewers. Most "children's programmes" are designed for much younger children and are of little or no interest to children 10–13 years of age. Special programmes for children of this age are rare. Denmark was quoted as an example of a country where there is a high-quality programme about and for young people, but even here for only one hour a week. It is well known that children of this age watch adult programmes which, all too often, are filled with violence. The Working Group therefore recommended that health authorities and professionals concerned with children should become more involved in working with television personnel, both to improve the quality of programmes in general and to develop more and better programmes for children and young people.

Finally, the Working Group considered the problem of organizing leisure activities for handicapped or chronically ill children in this age-group. It is essential to remember that such children also have leisure needs; indeed, the limitations imposed by their handicap often produce boredom and an exaggerated need for leisure. Considerable creativity and innovation are often required in seeking leisure time activities for these children. One example is the "leisure week-end" programme, in which adults volunteer to take small groups of handicapped children to the countryside for the week-end so as to provide both leisure in an expanded environment for the children and relief for the children's parents from the difficult task of rearing a handicapped child. Other examples of leisure programmes for these children were cited, including holiday camps for children with particular handicaps, and specially designed competitive games involving large numbers of handicapped children. In planning all such programmes, it is necessary to recall the socialization problems resulting from the segregation of deviants, and therefore to integrate their leisure activities with those of normal children whenever possible.

In discussing solutions to the problems of leisure activities for these children (i.e., the development of programmes), the Working Group recognized that such services are, in general, organized in two different ways in the European Region. In the eastern European countries, there is an external (extrafamilial) support system for children of this age, and leisure activities are incorporated into this system. In the western European countries, no such external support system exists and leisure activities must be included in the more general family support system. Both systems have advantages – for example, the external support system encourages wider participation and a more systematic approach, while the family support system encourages local initiative and flexibility – and it is important for planners to recognize both advantages and disadvantages when developing leisure programmes. In both types of system, however, it is both possible and important to incorporate a "leisure activities section" into the structure of the official organization serving children and young people. Leisure activities will then not be forgotten, but will receive their proper emphasis, and can be integrated and coordinated with the other services for children and young people by calling on the resources of other sections.

In planning leisure programmes for children in this age-group, it was suggested that three basic criteria should be met. Firstly, every community should provide space for the leisure activities of such children. All too often, children have difficulty in finding a place to go to – "keep off the grass", "children not allowed" – and playgrounds are small, confined and designed mainly for much younger children. The space provided need not be traditional in character. It can be a blocked off street, a condemned, but safe old building, etc., but the children must feel welcome and know it is "theirs". Secondly, a variety of possibilities must be available to the children, and should differ not only in the types of activities offered, but also in the amount of adult supervision. Thirdly, children must have freedom of choice as to the type of activity they wish to participate in. It is only if the individual is free to choose to do something that the activity chosen can be considered leisure.

The Working Group reviewed a number of leisure activities now provided in various areas of the Region, each of which has particular advantages which cannot be reviewed in detail here. Some of these activities are as follows.

(1) School clubs which offer leisure activities after school; these are of special value where both parents work.

(2) Youth organizations, such as pioneer clubs and boy scouts.

(3) Summer camps or holiday camps, usually located in the countryside.

(4) Sports clubs for children interested in pursuing a particular sport.

(5) Children's libraries and children's theatres; the latter can be organized so that the children can plan, write and perform their own plays for their peers and community.

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(6) A "free" play area where space, building materials, animals, and other items are provided. This new form of leisure activity is provided for children in this age-group in a few places in the Region, and goes under different names, e.g., "Robinson's garden" in Geneva, "building playground" in Copenhagen, etc. The principle is that the children are provided with an area of their own and with suitable materials and then, with a minimum of adult supervision, construct their own houses, stores, cages for the animals, etc. This allows for creativity, initiative, the possibility of organizing themselves, as well as responsibility for each other, and for their materials and animals.

This list of organized leisure activities is, of course, by no means exhaustive. In addition to these more highly organized group leisure activities, the Working Group recommended that planners should also consider ways of extending the leisure activities of individual children in such a way as to increase both the physical activity and social responsibility of children in this age-group. For example, such children can be given the opportunity of volunteering to deliver mail, or of assisting older or handicapped neighbours by shopping for them. Such daily leisure activities, performed by choice, can provide a valuable tool in the socialization of children in this age-group.

4. SOLUTIONS

While possible solutions of specific problems have been presented together with those problems, this section will deal with two types of service – educational programmes and health programmes – intended to assist in satisfying the needs and solving the problems of children 10–13 years of age.

4.1 Education as a solution

4.1.1 *Schools*

Most of the children in the European Region 10–13 years of age are still spending a major proportion of their waking hours in school. Because of this fact, the Working Group discussed recent developments in schools and their possible role in solving the problems of children in this age-group. Recent changes in children and society, including an earlier onset of puberty, increasing use of the mass media, an information explosion, changing family patterns, and changing parental roles, make it especially important to evaluate the educational programmes for these children.

A number of recent trends in education have been developed to meet these recent changes. Education has been increasingly democratized, and the role of children in the decision-making process at school expanded. The general trend toward less authoritarian ways includes a more individualistic approach to children and their needs and differences. Other trends have been towards increasing the flexibility of the school structure by grouping children according to level of knowledge or interests and needs, rather than by chronological age. There has also been an emphasis on learning how to learn, rather than on mere acquisition of facts.

One other recent trend in education was discussed at length by the Working Group -- that towards opening the doors of the school to increasing cooperation with the family, the medical and social institutions and the community. This open-door policy has many facets and ramifications. Thus it involves increased cooperation between teachers and parents, and consequently communication in both directions. This is facilitated, e.g., by home visits by the teacher (already practised in at least one country in the Region) and by parent participation in discussions at school about their own children.

The open-door policy also involves improved communication between the school child and the community in which the school is located. Such communication can take a variety of forms, including the allocation of school time to community projects[a] and to work in a regular community setting, such as a factory.

At the professional level, the open-door policy can include an increasing interdisciplinary approach at several different levels. At the academic level, there can be increasing collaborative research involving medicine, education, social science, etc. At the administrative level, there can be greater collaboration among health authorities, social authorities and educational authorities. At the level of the school, the increasing interdisciplinary approach can take several forms: interdisciplinary in-service education programmes in the schools involving teachers, psychologists, social workers, school physicians, and school nurses; interdisciplinary case conferences, where children who are presenting problems at school can be discussed by teachers, school psychologists, school administrators, school physicians, school nurses, parents and, when appropriate, the child himself. Such collaboration is facilitated if it is possible for the school physician also to be the family physician.

The Working Group endorsed the open-door policy as a way of bringing about a team approach to the solution of problems of schoolchildren in this age-group. Such a team can include children, parents, teachers, school administrators, school health personnel, professional workers in the community and ordinary members of that community.

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[a] *op cit.*

The Working Group touched on a number of problems with regard to the school which still remain unsolved. An early sign of a faulty educational programme for children 10–13 years of age is frustration in the teacher and/or the child; it would therefore be desirable, if possible, to find objective measures of such frustration. Schools need to become more flexible and more accommodating towards deviations in children of this age. In this regard, there is a need to find effective ways of using development profiles in schools, as well as effective ways of providing compensatory socialization programmes in them. Finally, as mentioned previously, school systems which separate children of this age into different educational streams need to be reevaluated.

4.1.2 *Vocational education*

In this and the next two sections, we shall be looking at more specific educational programmes which are particularly important to children 10–13 years of age. In all the three types of educational programme, namely vocational, health and sexual, it is important to distinguish between objectives (including those of society, the family and the child) and methods designed to achieve these objectives. It is also particularly important to distinguish between unconscious and conscious learning.

Vocational education is important for children 10–13 years of age because it is during this period that they begin to concern themselves with the choice of their career and work. In the setting of objectives for vocational education for these children, both at the level of society and that of the family, the question must eventually be raised – what sort of world do we want for future generations? This is necessary because the social and cultural environment will influence, both at the conscious and the unconscious level, the career choice of these children, and this career choice will, in turn, influence the social and cultural environment of the future. When objectives for vocational education are set, it is equally important that such objectives should fit in with local community employment and career needs and objectives.

The family still has an overriding influence on the career choice of children, and for this reason the school must work closely with families, both in developing objectives for vocational education programmes and in counselling individual children.

The school can make two important contributions to the vocational education of children of this age. Firstly, it can develop a programme to assess the abilities (physical and intellectual), vocational aptitudes and vocational interests of the children. Secondly, it can develop a programme of vocational counselling, which will include giving the children information on their own abilities, aptitudes and interests, the job market, and the social conditions associated with different vocations. Armed with such information, the children will then be better able to make their own rational and intelligent choices with regard to their future careers.

4.1.3 *Health education*

While most health-related unconscious learning and attitude formation has occurred by 10 years of age, many important health attitudes and habits are still developing or are still susceptible to change. The objectives of health education programmes must match local health needs and problems. Thus, in the developing areas of the Region, such programmes for children in this age-group should focus on nutrition, infections, etc., while in the developed areas they should focus on accidents, chronic respiratory diseases, etc.

With regard to the methods of health education, the mass media are very important in this age-group, and health professionals need to become more involved in improving this source of information. As described in the report of the first Working Group[a], schoolchildren's participation in health projects in the community is another effective method which might be more widely used. It may be that the best method of health education with children 10–13 years of age is to give them all the available health information, including that on risks, and then allow them to choose their personal health behaviour, based on this information.

Systematic knowledge concerning health education programmes in the schools in the European Region is lacking; for this reason, the Working Group recommended that consideration should be given to a survey of these programmes in the Region.

4.1.4 *Sex education*

By 10 years of age, most unconscious learning of attitudes towards sex have been formed, but the period 10–13 years of age is important because the influence of peer attitudes with regard to sexual behaviour is rapidly increasing and because sexual maturation, in most cases, begins and precursors or the earliest patterns of sexual behaviour begin to appear. By 13 years of age, therefore, children should have received all the necessary sexual information (facts).

In the past, most of the objectives of sex education were negative – prevention of pregnancy, prevention of venereal disease, etc. – but positive objectives are also needed, such as overcoming physical difficulties, the production of wanted children and the achievement of rewarding human relationships. With regard to sex education methodology, the key question is to determine who can best provide such education, and more investigation of this issue is needed.

Effective sex education programmes are also needed for the parents and teachers of these children. In fact, the Working Group felt that sex education

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[a] *op cit.*

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needs to be broadened to become family life education, and to include teaching about parental roles, sex roles, child care (possibly with students working in a school-based child-care centre), and problems of family interaction, as well as about sex.

The Group felt that research on sex education was needed on a variety of issues, including the formation of sexual attitudes and behaviour patterns, and follow-up evaluations of different approaches to sex education. It was recommended that consideration should be given to convening a meeting in the future on health education and sex education in schools.

With regard to vocational education, health education and sex education, it is clear that, for all three types of educational programme, close collaboration between parents, teachers and children is essential.

4.2 Health services as a solution

4.2.1 *Existing health services*

In discussing the present-day school health services for children 10–13 years of age, the Working Group reviewed information on these services in the Region. Until recently, little or no information has been available on them. The Maternal and Child Health unit of the WHO Regional Office for Europe, recognizing this lack of information, has begun by making a valuable survey of school health statistics in the Region.[a] The Working Group discussed the findings of this survey, some of which have been described in section 4.1 of the report of the first Working Group.

The survey revealed that, in general, school health statistics are poorly collected and lack operational definitions of findings and diagnoses and of criteria for specific measures. The statistics which are collected emphasize services rendered, not problems found, and there is little feedback to service providers. None of the countries studied had an effective, systematic, nationwide system of statistics on school health problems or programmes.

While the first Working Group focused on the implications of this survey with regard to the role of school health personnel, the present Working Group was more concerned with the implications with regard to the content of services. The authors of the survey reported that those responsible for the content of school health services in the countries concerned recognized that present-day services, in general, are not meeting the present-day problems of children 10–13 years of age, and they are anxious for suggestions for improving the content of the services. For example, recognition of the importance of early detection of defects has resulted in a desirable shift of screening

[a] **Maier, E. & Vuille, J.** *The present European situation in school health statistics.* Copenhagen, World Health Organization, Regional Office for Europe (in preparation)

programmes towards younger children. What, however, should they be screening for between 10 and 13 years of age? Furthermore, some of the screening procedures used have perhaps resulted in "overscreening", e.g., screening for albuminuria in boys or annual chest X-rays of children living in developed areas. The survey also revealed that, all too often, what takes place in the school health services is inadequately linked with what takes place in the rest of the school or the community. While there have been occasional attempts in these countries to reform the content of school health services, there have not been, unfortunately, any attempts to measure the results of these changes systematically.

The Working Group made several recommendations with regard to existing school health services for these children. Countries should aim for the development of a single, continuous health record for each child from birth to adulthood, of which the school health record should be an integral part. It was further recommended that an attempt should be made, perhaps by the WHO European Regional Office, to develop a simple, standardized school health statistical system which could be used by all countries in the Region.

The Working Group also recognized the urgent need for systematic, detailed documentation, through controlled scientific study, of the actual activities performed by existing school health services. The Working Group was aware of only one current attempt in the Region to document scientifically the detailed content of an on-going school health service programme. It therefore recommended that further research of this type should be undertaken, preferably with an emphasis on the study of school nurses' activities. The school nurse was seen as the key person in the school health service system, but little is known of the work that she does, or does not, perform. For example, it was felt that the school nurse is in a position to play an important role in recognizing children in this age-group with poor socialization and in providing compensatory socialization in the school.

4.2.2 *Future health services*

The Working Group, in addition to recommending research on existing school health services, also recognized the need for the development of experimental school health service programmes in which new services are tried out and their results carefully measured. Depending on those results, such experimental programmes can be further modified and then used as models for the development of new service programmes. Several examples of experimental school health programmes of this type were presented to and discussed by the Working Group and will be briefly reviewed here.

The first experimental school health programme presented was tried out in a large school serving children 11–15 years of age. The programme was designed to: (1) focus on children at risk and problem children; (2) focus the activities of the school physician and school nurse on what

they are in a position to do best; (3) improve collaboration between the school health services and the community services; and (4) increase the interdisciplinary nature of the services.

The routine health appraisal consisted, firstly, of a physical examination carried out every three years by the family physician who reported directly to the school. Secondly, sight was tested annually at school by parents trained by the school nurse. Thirdly, and most importantly, the children were kept under observation by the teachers in the classroom. For this purpose, the teachers were instructed by the school physician and school nurse in the health observation of children of this age, and the teachers in turn referred possible problems to the school nurse for further evaluation.

A special health appraisal system for children at risk was also developed. In collaboration with the school administrators, a policy was established that any child in the school who presented a behaviour problem, was chronically absent from school, performed academically below the level expected, was to be placed in a special education class or special school, was not to go up to the next class, or was to be expelled, had first to be evaluated by the school health team before any action was taken by the school. Such a child was referred to the school nurse, who gathered all relevant information from the school, family, family physician, and other community agencies, and then compiled a report. The school physician then reviewed the report and examined the child. An interdisciplinary conference was then held in the school to decide the disposition of the case.

Emergency medical care for acute illness or accidents in this school was ensured by training specified school administrative (non-medical) personnel in the provision of such care.

In addition, the school physician and school nurse served as "consultants" to the school in the development of policies for the surveillance of the school environment for possible health hazards, and the management of school staff suspected of having physical or mental health problems.

The results of this experimental school health programme can be only briefly presented here. Most of the children referred to the school health team for special health appraisal were found to have very complex, long-standing problems which included primary or secondary emotional and/or social difficulties. The medical and social institutions in the community were in many cases inadequate to deal with the complexities of these problems. Because of changes in the management of these children in the schools which resulted from the appraisal, however, a reevaluation of all of these children one year later showed that approximately half of them had improved in the school setting.

The second experimental school health programme presented was an interdisciplinary case conference developed in a school. Children in this

school having the most intractable difficulties were referred to the school psychologist and school nurse. These two together selected cases for the conference. Before the meeting, each of the following evaluated the case and prepared a report: the teacher, school nurse, school physician, school psychologist, school social worker (who made a home visit), and school principal. At the case conference, each of the above presented their report, and this was followed by a general discussion and decision as to disposition.

The results, briefly, were that great progress was made with these children as a result of the case conference. Two difficulties which the case conference experienced – questions of professional ethics in sharing confidential family information, and occasional difficulty in gaining parental acceptance of the disposition decided upon – were both felt to be the result of not including the parents in the conference; the programme was therefore modified so as to include them.

The third experimental school health programme presented involved expanding the role children play in managing their own acute illnesses at school. Before this programme began, the children in the school were tested on their level of knowledge about their bodies, health and disease. The experimental programme was then begun, as follows. Any child in the classroom who, for any reason, decided he was not well, instead of asking for permission to go to the nurse's office, *told* the teacher that he was going to do so. The school nurse (specially trained for this experiment) asked the child what he thought the problem was and what he thought should be done (e.g., lie down for a few minutes, go home, call an ambulance, etc.). The child and nurse then discussed the problem, and if the nurse found the child's suggestion reasonable, it was accepted. If the suggestion was not reasonable, the nurse counselled the child until a mutually agreed on disposition was found. Careful records were kept of the way in which the children used this free-access, self-care system.

The results, briefly, were as follows. A post-test of these children showed a marked increase in their level of knowledge of their bodies, health and disease – health education is very effective when it is applied to oneself in a concrete situation. In most cases the self-management was reasonable and effective. By the age of 10 years, the patterns of use of this system were the same as found among adults using a free-access medical-care system (for example, 10% were overusers) and the child's pattern of use correlated with parents' use of medical care in the community.

The Working Group recognized that experimental programmes, such as the three just reviewed, must be tailored to the characteristics of the school health system and general child health system in the community in question. Nevertheless, such experiments are important as trials of new ideas and services which can later be modified to fit local health-care systems.

5. RECOMMENDATIONS

The final recommendations resulted from a careful evaluation of the problems of children 10–13 years of age. Consequently, the reader should remember that these recommendations gain meaning and significance only if account is taken of the main body of this report. For this reason, each recommendation is followed by the number of the section from which the recommendation comes so that the reader can refer back to the issues relevant to that recommendation.

(1) Research in physical and sexual growth and development in this age-group should: include the development, by each country, of its own physical and sexual growth standards based on a representative sample taken at least every ten years; focus on environmental factors; include the study of functional components; include psychological and social consequences; include a search for better parameters of growth and sexual maturation; make greater provision for collaboration among researchers (section 3.1).

(2) More research is needed on patterns of morbidity for children in this age-group (section 3.1).

(3) Screening and assessment programmes for these children should include a non-specific complaint or risk category (section 3.1).

(4) The management of chronic disease in these children should aim at normalizing the psychological and social environment to the greatest possible extent by means of: outpatient rather than inpatient treatment whenever possible; inpatient treatment in children's departments where they are provided with facilities for education, recreation and frequent family contact; a greater role for the family and the child in the management of the illness; placement in as normal as possible a school setting (section 3.1).

(5) Every effort should be made to find reliable instruments in order to establish development profiles for children 10–13 years of age, including biological, psychological and social characteristics (section 3.2).

(6) Education of children, parents and teachers in growth and development is needed and should use the principles of the Tanner Scale and the development profile. In addition, knowledge about behaviour patterns in children of this age-group should be more widely disseminated, and the family, school and health personnel should work together in the management of behaviour problems (section 3.2).

(7) Children of this age-group found to have a psychological problem should undergo medical examination (section 3.2).

(8) More research is needed on the psychological development of children of this age-group, using social conditions as a starting point (section 3.2).

(9) Programmes (schools, sports, etc.) which segregate children of this age-group who are physically or intellectually deviant (in either direction) need to be reevaluated in the light of their psychological and social effects. There is also need for a thorough reassessment of the streaming policy, and of other school policies, in the light of their effect on children (section 3.2).

(10) The incidence and prevalence of suicide in children of this age-group needs close attention (section 3.2).

(11) School health personnel need to develop programmes for the prevention of psychological problems and actively to seek out children in need of help (section 3.2).

(12) More research is urgently needed on social deviance in this age-group and should include attempts to develop instruments to evaluate the level of socialization of these children. Programmes aimed at the management of social deviance in this age-group cannot wait, however, for the results of such research and should: focus on the processes of socialization; take into account both microsocial and macrosocial factors; include preventive measures from the age of 10 and onwards and focus on risk groups; include curative elements aimed at resocialization; include primary and secondary deviance and positive and negative deviance; avoid reinforcing deviance; focus on compensatory socialization programmes in the school; involve close cooperation among parents, school, and social institutions in the community (section 3.3.1).

(13) A meeting should be organized on the physical education and physical culture of schoolchildren; it would, *inter alia*, consider the role of physical activity in development, the role of sports, and physical and psychological limitations (section 3.3.2).

(14) Health authorities should work actively to improve the quality of television programmes so that they provide higher quality education and leisure for children (section 3.3.2).

(15) Leisure programmes for this age-group should: include a leisure activities section in official public organizations serving children and young people; include programmes for handicapped children; provide a suitable space in every community for leisure activities for these children; provide a variety of leisure possibilities; allow the children freedom of choice in the type of leisure activity they wish to participate in (section 3.3.2).

(16) Changes in educational programmes for children 10–13 years of age should include opening the doors of schools so as to ensure: greater cooperation between parents and teachers; better communication between the school child and the community; increasing interdisciplinary collaborative research; greater cooperation among health, education and social authorities; interdisciplinary in-service education programmes in schools; interdisciplinary case conferences in schools (section 4.1.1).

(17) Schools for children in this age-group, working in cooperation with parents and the community, should develop vocational education programmes which include vocational assessment and vocational counselling (section 4.1.2).

(18) Health education programmes for children in this age-group should: match local health needs and problems; provide for the participation of schoolchildren in community health projects; focus on providing the children with all available knowledge while allowing them to choose their own health behaviour based on this information. Consideration should be given to a survey of school health education programmes in the European Region. More effective sex education programmes are needed which: provide all necessary information by 13 years of age; include positive objectives; include children, parents, and teachers; include a family life education approach. Consideration should be given to convening a meeting on health and sex education in schools (sections 4.1.3 and 4.1.4).

(19) Countries should aim at developing a single continuous health record from birth to adulthood. In addition, efforts should be made to standardize school health statistics in the European Region, including the use of standardized forms (section 4.2.1).

(20) There is an urgent need for research on school health services including systematic measurements of present practices, with emphasis on school nurse activities, and the development of experimental school health programmes (sections 4.2.1 and 4.2.2).

Annex

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